CLAIM APPEAL PROCESS

Overview

Under TRIP there are appeal procedures to follow when dissatisfied with a claim determination.

Initial Review of Claim Determination

A TCHP plan participant who believes an error has been made in the benefit amount allowed or disallowed must contact the plan administrator within 180 days of the date of the initial claim determination.

A customer service representative will be able to provide more information regarding the denial. In some cases, additional information such as an operative report or x-rays may be required to determine if additional benefits are available. In some cases, a special review by a physician or dentist may be warranted. Each case will be analyzed and considered on its own merits.

If dissatisfied with the outcome of the review, plan participants are entitled to file a grievance or appeal. Contact the plan administrator for information on the procedure. **The plan administrator's internal review process must be used to the fullest extent prior to contacting the CMS/Group Insurance Division regarding a final determination.**

Managed Care Plan Appeal Process

If enrolled in a managed care plan, call your managed care plan or consult the plan's Summary Plan Description or Subscription Certificate for appeals process information.

Final Claim Determination

If, after the plan administrator's review a plan participant still feels that the claim determination is not in accordance with the published benefit coverage, a Final Determination by the CMS/Group Insurance Division may be requested within 60 days of the date of the Initial Review determination. The request must be in writing from the plan participant and be accompanied by all medical documentation supporting the reasons for reconsideration of the benefit determination.

Submit Documentation to:

CMS/Group Insurance Division
Room 600, Stratton Office Building
Springfield, IL 62706

Appealing the Final Claim Determination

If a plan participant is still not satisfied, an appeal of the Final Determination may be made to an appeal committee within 60 days of the Final Review determination. This committee will review the documentation and facts presented in the Final Determination.

The appeal committee will consider the merits of each individual case. If new information is presented to the committee which was not presented during the Final Determination, the appeal will be returned to the CMS/Group Insurance Division for review and reconsideration of the determination.

Plan participants will be notified in writing of the outcome of the committee's review. The decision of the appeal committee shall be final and binding on all parties.

Submit Documentation to:

CMS/Bureau of Benefits
Room 616, Stratton Office Building
Springfield, IL 62706